



General Assembly

Substitute Bill No. 433

February Session, 2016

* SB00433 INS 031716 *

**AN ACT CONCERNING STANDARDS AND REQUIREMENTS FOR
HEALTH CARRIERS' PROVIDER NETWORKS AND CONTRACTS
BETWEEN HEALTH CARRIERS AND PARTICIPATING PROVIDERS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-472f of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2017*):

3 (a) [Each insurer, health care center, managed care organization or
4 other entity that delivers, issues for delivery, renews, amends or
5 continues an individual or group health insurance policy or medical
6 benefits plan, and each preferred provider network, as defined in
7 section 38a-479aa, that contracts with a health care provider, as defined
8 in section 38a-478, for the purposes of providing covered health care
9 services to its enrollees, shall maintain a network of such providers
10 that is consistent with the National Committee for Quality Assurance's
11 network adequacy requirements or URAC's provider network access
12 and availability standards.] As used in this section:

13 (1) "Authorized representative" means (A) an individual to whom a
14 covered person has given express written consent to represent the
15 covered person, (B) an individual authorized by law to provide
16 substituted consent for a covered person, or (C) the covered person's
17 treating health care provider when the covered person is unable to
18 provide consent or a family member of the covered person;

19 (2) "Covered benefit" or "benefit" means those health care services to
20 which a covered person is entitled under the terms of a health benefit
21 plan;

22 (3) "Covered person" has the same meaning as provided in section
23 38a-591a;

24 (4) "Essential community provider" means a health care provider or
25 facility that (A) serves predominantly low-income, medically
26 underserved individuals and includes covered entities, as defined in 42
27 USC 256b, as amended from time to time, or (B) is described in 42 USC
28 1396r-8(c)(1)(D)(i)(IV), as amended from time to time;

29 (5) "Facility" has the same meaning as provided in section 38a-591a;

30 (6) "Health benefit plan" has the same meaning as provided in
31 section 38a-591a;

32 (7) "Health care provider" has the same meaning as provided in
33 section 38a-477aa;

34 (8) "Health care services" has the same meaning as provided in
35 section 38a-478;

36 (9) "Health carrier" has the same meaning as provided in section
37 38a-591a;

38 (10) "Intermediary" means a person, as defined in section 38a-1,
39 authorized to negotiate and execute health care provider contracts
40 with health carriers on behalf of health care providers or a network;

41 (11) "Network" means the group or groups of participating
42 providers providing health care services under a network plan;

43 (12) "Network plan" means a health benefit plan that requires a
44 covered person to use, or creates incentives, including financial
45 incentives, for a covered person to use, health care providers or
46 facilities that are managed, owned, under contract with or employed

47 by the health carrier;

48 (13) "Participating provider" means a health care provider or a
49 facility that, under a contract with a health carrier or such health
50 carrier's contractor or subcontractor, has agreed to provide health care
51 services to such health carrier's covered persons, with an expectation
52 of receiving payment or reimbursement directly or indirectly from the
53 health carrier, other than coinsurance, copayments or deductibles;

54 (14) "Primary care" means health care services for a range of
55 common physical, mental or behavioral health conditions, provided by
56 a health care provider;

57 (15) "Primary care provider" means a participating health care
58 provider designated by a health carrier to supervise, coordinate or
59 provide initial health care services or continuing health care services to
60 a covered person, and who may be required by the health carrier to
61 initiate a referral for specialty care and maintain supervision of health
62 care services provided to the covered person;

63 (16) "Specialist" means a health care provider who (A) focuses on a
64 specific area of physical, mental or behavioral health or a specific
65 group of patients, and (B) has successfully completed required training
66 and is recognized by this state to provide specialty care. "Specialist"
67 includes a subspecialist who has additional training and recognition
68 beyond that required for a specialist;

69 (17) "Specialty care" means advanced medically necessary care and
70 treatment of specific physical, mental or behavioral health conditions,
71 or those conditions that may manifest in particular ages or
72 subpopulations, that are provided by a specialist in coordination with
73 a health care provider;

74 (18) "Telemedicine" or "telehealth" has the same meaning as
75 "telehealth", as defined in section 19a-906; and

76 (19) "Tiered network" means a network that identifies and groups

77 some or all types of health care providers and facilities into specific
78 groups to which different participating provider reimbursement,
79 covered person cost-sharing or participating provider access
80 requirements, or any combination thereof, apply for the same health
81 care services.

82 (b) The provisions of this section and sections 2 and 3 of this act
83 shall apply to all health carriers that deliver, issue for delivery, renew,
84 amend or continue a network plan in this state.

85 (c) (1) (A) Each health carrier shall establish and maintain a network
86 that includes a sufficient number and appropriate types of
87 participating providers, including those that serve predominantly low-
88 income, medically underserved individuals, to assure that all covered
89 benefits will be accessible to all such health carrier's covered persons
90 without unreasonable travel or delay.

91 (B) Each health carrier shall assure that all covered persons have
92 access to emergency services, as defined in section 38a-477aa, twenty-
93 four hours a day, seven days a week.

94 (2) The Insurance Commissioner shall determine the sufficiency of a
95 health carrier's network in accordance with the provisions of this
96 subsection and may establish sufficiency by reference to any
97 reasonable criteria, including, but not limited to, (A) the ratio of
98 participating providers to covered persons by specialty, (B) the ratio of
99 primary care providers to covered persons, (C) the geographic
100 accessibility of participating providers, (D) the geographic variation
101 and dispersion of the state's population, (E) the wait times for
102 appointments with participating providers, (F) the hours of operation
103 of participating providers, (G) the ability of the network to meet the
104 needs of covered persons that may include low-income individuals,
105 children and adults with serious, chronic or complex conditions or
106 physical or mental disabilities or individuals with limited English
107 proficiency, (H) the availability of other health care delivery system
108 options, such as telemedicine, telehealth, centers of excellence and

109 mobile clinics, (I) the volume of technological and specialty care
110 services available to serve the needs of covered persons who require
111 technologically advanced or specialty care services, (J) the extent to
112 which participating health care providers are accepting new patients,
113 (K) the degree to which (i) participating health care providers are
114 authorized to admit patients to hospitals participating in the network,
115 and (ii) hospital-based health care providers are participating
116 providers, and (L) the regionalization of specialty care.

117 (d) (1) Each health carrier shall establish and maintain a process to
118 ensure that a covered person receives a covered benefit at an in-
119 network level, including an in-network level of cost-sharing, from a
120 nonparticipating provider, or shall make other arrangements
121 acceptable to the commissioner, when:

122 (A) The health carrier has a sufficient network but does not have (i)
123 a type of participating provider available to provide the covered
124 benefit to the covered person, or (ii) a participating provider available
125 to provide the covered benefit to the covered person without
126 unreasonable travel or delay; or

127 (B) The health carrier has an insufficient number or type of
128 participating providers available to provide the covered benefit to the
129 covered person without unreasonable travel or delay.

130 (2) Each health carrier shall disclose to a covered person the process
131 to request a covered benefit from a nonparticipating provider, as
132 provided under subdivision (1) of this subsection, when:

133 (A) The covered person is diagnosed with a condition or disease
134 that requires specialty care; and

135 (B) The health carrier (i) does not have a participating provider of
136 the required specialty with the professional training and expertise to
137 treat or provide health care services for the condition or disease, or (ii)
138 cannot provide reasonable access to a participating provider of the
139 required specialty with the professional training and expertise to treat

140 or provide health care services for the condition or disease without
141 unreasonable travel or delay.

142 (3) The health carrier shall deem the health care services such
143 covered person receives from a nonparticipating provider pursuant to
144 subdivision (2) of this subsection to be health care services provided by
145 a participating provider, including counting the covered person's cost-
146 sharing for such health care services toward the maximum out-of-
147 pocket expenses limit applicable to health care services received from
148 participating providers under the health benefit plan.

149 (4) The health carrier shall ensure that the processes described
150 under subdivisions (1) and (2) of this subsection address a covered
151 person's request to obtain a covered benefit from a nonparticipating
152 provider in a timely fashion appropriate to the covered person's
153 condition. The time frames for such processes shall mirror those set
154 forth in subsections (e) and (f) of section 38a-591g for external reviews
155 of adverse determinations and final adverse determinations.

156 (5) The health carrier shall document all requests from its covered
157 persons to obtain a covered benefit from a nonparticipating provider
158 pursuant to this subsection and shall provide such documentation to
159 the commissioner upon request.

160 (6) No health carrier shall use the process described in subdivisions
161 (1) and (2) of this subsection as a substitute for establishing and
162 maintaining a sufficient network as required under subsection (b) of
163 this section. No covered person shall use such process to circumvent
164 the use of covered benefits available through a health carrier's network
165 delivery system options.

166 (7) Nothing in this subsection shall be construed to affect any rights
167 or remedies available to a covered person under sections 38a-591a to
168 38a-591g, inclusive, or federal law relating to internal or external
169 claims grievance and appeals processes.

170 (e) (1) Each health carrier shall:

171 (A) Maintain adequate arrangements to assure that such health
172 carrier's covered persons have reasonable access to participating
173 providers located near such covered persons' places of residence or
174 employment. In determining whether a health carrier has complied
175 with this subparagraph, the commissioner shall give due consideration
176 to the relative availability of health care providers with the requisite
177 expertise and training in the service area under consideration;

178 (B) Monitor on an ongoing basis the ability, clinical capacity and
179 legal authority of its participating providers to provide all covered
180 benefits to its covered persons;

181 (C) Establish and maintain procedures by which a participating
182 provider will be notified on an ongoing basis of the specific covered
183 health care services for which such participating provider will be
184 responsible, including any limitations on or conditions of such
185 services;

186 (D) Ensure that participating providers provide covered benefits to
187 all covered persons without regard to a covered person's enrollment in
188 a network plan as a private purchaser of such network plan or as a
189 participant in a publicly financed health care program, except that
190 nothing in this subparagraph shall be construed to apply to
191 circumstances when a participating provider should not provide
192 services due to limitations arising from lack of training, experience or
193 skill or license restrictions;

194 (E) Notify participating providers of their obligations, if any, (i) to
195 collect applicable coinsurance, deductibles or copayments from
196 covered persons pursuant to a covered person's health benefit plan,
197 and (ii) to notify covered persons of such covered persons' financial
198 obligations for noncovered benefits;

199 (F) Establish and maintain procedures by which a participating
200 provider may determine in a timely manner at the time benefits are
201 provided whether an individual is a covered person or is within a

202 grace period for payment of premium during which such health carrier
203 may hold a claim for health care services pending receipt of payment
204 of premium by such health carrier;

205 (G) Timely notify a health care provider or facility, when such
206 health carrier has included such health care provider or facility as a
207 participating provider for any of such health carrier's health benefit
208 plans, of such health care provider's or facility's network participation
209 status;

210 (H) Notify participating providers of the participating provider's
211 responsibilities with respect to such health carrier's applicable
212 administrative policies and programs, including, but not limited to,
213 payment terms, utilization review, quality assessment and
214 improvement programs, credentialing, grievance and appeals
215 processes, date reporting requirements, reporting requirements for
216 timely notice of changes in practice such as discontinuance of
217 accepting new patients, confidentiality requirements, any applicable
218 federal or state programs and obtaining necessary approval of referrals
219 to nonparticipating providers; and

220 (I) Establish and maintain procedures for the resolution of
221 administrative, payment or other disputes between the health carrier
222 and a participating provider.

223 (2) No health carrier shall:

224 (A) Offer or provide an inducement to a participating provider that
225 would encourage or otherwise incentivize a participating provider to
226 provide less than medically necessary health care services to a covered
227 person;

228 (B) Prohibit a participating provider from (i) discussing any specific
229 or all treatment options with covered persons, irrespective of such
230 health carrier's position on such treatment options, or (ii) advocating
231 on behalf of covered persons within the utilization review or grievance
232 and appeals processes established by such health carrier or a person

233 contracting with such health carrier or in accordance with any rights or
234 remedies available to covered persons under sections 38a-591a to 38a-
235 591g, inclusive, or federal law relating to internal or external claims
236 grievance and appeals processes; or

237 (C) Penalize a participating provider because such participating
238 provider reports in good faith to state or federal authorities any act or
239 practice by such health carrier that jeopardizes patient health or
240 welfare.

241 (f) (1) Each health carrier shall develop standards, to be used by
242 such health carrier and its intermediaries, for selecting and tiering, as
243 applicable, participating providers and each health care provider
244 specialty.

245 (2) No health carrier shall establish selection or tiering criteria in a
246 manner that would (A) allow the health carrier to discriminate against
247 high-risk populations by excluding or tiering participating providers
248 because they are located in a geographic area that contains populations
249 or participating providers that present a risk of higher-than-average
250 claims, losses or health care services utilization, or (B) exclude
251 participating providers because they treat or specialize in treating
252 populations that present a risk of higher-than-average claims, losses or
253 health care services utilization. Nothing in this subdivision shall be
254 construed to prohibit a health carrier from declining to select a health
255 care provider or facility for participation in such health carrier's
256 network who fails to meet legitimate selection criteria established by
257 such health carrier.

258 (3) No health carrier shall establish selection criteria that would
259 allow the health carrier to discriminate, with respect to participation in
260 a network plan, against any health care provider who is acting within
261 the scope of such health care provider's license or certification under
262 state law. Nothing in this subdivision shall be construed to require a
263 health carrier to contract with any health care provider or facility
264 willing to abide by the terms and conditions for participation

265 established by such health carrier.

266 (4) Each health carrier shall make the standards required under
267 subdivision (1) of this subsection available to the commissioner for
268 review and shall make available to the public a plain language
269 description of such standards.

270 (5) Nothing in this subsection shall require a health carrier, its
271 intermediaries or health care provider networks with which such
272 health carrier or intermediary contracts to (A) employ specific health
273 care providers acting within the scope of such health care providers'
274 license or certification under state law who meet such health carrier's
275 selection criteria, or (B) contract with or retain more health care
276 providers acting within the scope of such health care providers' license
277 or certification under state law than are necessary to maintain a
278 sufficient network.

279 (g) (1) (A) A health carrier and participating provider shall provide
280 at least sixty days' written notice to each other before the health carrier
281 removes a participating provider from the network or the participating
282 provider leaves the network. Each participating provider that receives
283 a notice of removal or issues a departure notice shall provide to the
284 health carrier a list of such participating provider's patients who are
285 covered persons under a network plan of such health carrier.

286 (B) A health carrier shall make a good faith effort to provide written
287 notice, not later than thirty days after the health carrier receives or
288 issues a written notice under subparagraph (A) of this subdivision, to
289 all covered persons who are patients being treated on a regular basis
290 by or at the participating provider being removed from or leaving the
291 network, irrespective of whether such removal or departure is for
292 cause.

293 (C) If the participating provider being removed from or leaving the
294 network is a primary care provider, the health carrier shall provide
295 written notice to all covered persons who are patients of such primary

296 care provider.

297 (2) (A) For the purposes of this subdivision:

298 (i) "Active course of treatment" means (I) an ongoing course of
299 treatment for a life-threatening condition, (II) an ongoing course of
300 treatment for a serious acute condition, (III) care provided during the
301 second or third trimester of pregnancy, or (IV) an ongoing course of
302 treatment for a condition for which a treating health care provider
303 attests that discontinuing care by such health care provider would
304 worsen the covered person's condition or interfere with anticipated
305 outcomes;

306 (ii) "Life-threatening condition" means a disease or condition for
307 which the likelihood of death is probable unless the course of such
308 disease or condition is interrupted;

309 (iii) "Serious acute condition" means a disease or condition that
310 requires complex ongoing care such as chemotherapy, radiation
311 therapy or postoperative visits, which the covered person is currently
312 receiving; and

313 (iv) "Treating provider" means a covered person's treating health
314 care provider or a facility at which a covered person is receiving
315 treatment, that is removed from or leaves a health carrier's network
316 pursuant to subdivision (1) of this subsection.

317 (B) (i) Each health carrier shall establish and maintain reasonable
318 procedures to transition a covered person, who is in an active course of
319 treatment with a participating health care provider or at a participating
320 facility that becomes a treating provider, to another participating
321 provider in a manner that provides for continuity of care. A covered
322 person shall be deemed to be in an active course of treatment if such
323 covered person has been treated on a regular basis by such
324 participating health care provider or at such participating facility.

325 (ii) In addition to the notice required under subdivision (1) of this

326 subsection, the health carrier shall provide to such covered person (I) a
327 list of available participating providers in the same geographic area as
328 such covered person who are of the same health care provider or
329 facility type, and (II) the procedures for how such covered person may
330 request continuity of care as set forth in this subparagraph.

331 (iii) Such procedures shall provide that:

332 (I) Any request for a continuity of care period shall be made by the
333 covered person or the covered person's authorized representative;

334 (II) A request for a continuity of care period, made by a covered
335 person who meets the requirements under subparagraph (B)(i) of this
336 subdivision or such covered person's authorized representative and
337 whose treating provider was not removed from or did not leave the
338 network for cause, shall be reviewed by the health carrier's medical
339 director after consultation with such treating provider; and

340 (III) For a covered person who is in the second or third trimester of
341 pregnancy, the continuity of care period shall extend through the
342 postpartum period.

343 (iv) The continuity of care period for a covered person who is
344 undergoing an active course of treatment shall extend to the earliest of
345 the following: (I) Termination of the course of treatment by the covered
346 person or the treating provider; (II) ninety days after the date the
347 participating provider is removed from or leaves the network, unless
348 the health carrier's medical director determines that a longer period is
349 necessary; (III) the date that care is successfully transitioned to another
350 participating provider; (IV) the date benefit limitations under the
351 health benefit plan are met or exceeded; or (V) the date the health
352 carrier determines care is no longer medically necessary.

353 (v) The health carrier shall only grant a continuity of care period as
354 provided under subparagraph (B)(iv) of this subdivision if the treating
355 provider agrees, in writing, (I) to accept the same payment from such
356 health carrier and abide by the same terms and conditions as provided

357 in the contract between such health carrier and treating provider when
358 such treating provider was a participating provider, and (II) not to
359 seek any payment from the covered person for any amount for which
360 such covered person would not have been responsible if the treating
361 provider was still a participating provider.

362 (h) (1) (A) Beginning January 1, 2017, a health carrier shall file with
363 the commissioner for review each existing network as of said date and
364 an access plan for each such network.

365 (B) For each new network a health carrier intends to offer after
366 January 1, 2017, such health carrier shall file with the commissioner for
367 review, within thirty days prior to the date such health carrier will
368 offer such new network, the new network and an access plan for such
369 new network.

370 (C) A health carrier shall notify the commissioner of any material
371 change to an existing network not later than fifteen business days after
372 such change and shall file with the commissioner an update to such
373 existing network not later than thirty days after such material change.
374 For the purposes of this subparagraph, "material change" means (i) a
375 change of twenty-five per cent or more in the participating providers
376 in a health carrier's network or the type of participating providers
377 available in a health carrier's network to provide health care services or
378 specialty care to covered persons, or (ii) any change that renders a
379 health carrier's network noncompliant with one or more network
380 adequacy standards, such as (I) a significant reduction in the number
381 of primary care or specialty care providers available in the network,
382 (II) a reduction in a specific type of participating provider such that a
383 specific covered benefit is no longer available to covered persons, (III)
384 a change to a tiered, multitiered, layered or multilevel network plan
385 structure, or (IV) a change in inclusion of a major health system, as
386 defined in section 19-508c, that causes a network to be significantly
387 different from what a covered person initially purchased.

388 (2) Each access plan required under subdivision (1) of this

389 subsection shall be in a form and manner prescribed by the
390 commissioner and shall contain descriptions of at least the following:

391 (A) The health carrier's network, including how the use of
392 telemedicine, telehealth or other technology may be used to meet
393 network access standards, if applicable;

394 (B) The health carrier's procedures for making and authorizing
395 referrals within and outside its network, if applicable;

396 (C) The health carrier's procedures for monitoring and assuring on
397 an ongoing basis the sufficiency of its network to meet the health care
398 needs of the populations that enroll in its network plans;

399 (D) The factors used by the health carrier to build its network,
400 including a description of the network and the criteria used to select
401 and tier health care providers and facilities;

402 (E) The health carrier's efforts to address the needs of covered
403 persons, including, but not limited to, children and adults, including
404 those with limited English proficiency or illiteracy, diverse cultural or
405 ethnic backgrounds, physical or mental disabilities and serious,
406 chronic or complex conditions. Such description shall include the
407 health carrier's efforts, when appropriate, to include various types of
408 essential community providers in its network;

409 (F) The health carrier's methods for assessing the health care needs
410 of covered persons and covered persons' satisfaction with the health
411 care services provided;

412 (G) The health carrier's method of informing covered persons of the
413 network plan's covered benefits, including, but not limited to, (i) the
414 network plan's grievance and appeals processes, (ii) the network plan's
415 process for covered persons to choose or change participating
416 providers in the network plan, (iii) the health carrier's process for
417 updating its participating provider directories for each of its network
418 plans; (iv) a statement of the health care services offered by the

419 network plan, including those health care services offered through the
420 preventive care benefit, if applicable; and (v) the network plan's
421 procedures for covering and approving emergency, urgent and
422 specialty care, if applicable;

423 (H) The health carrier's system for ensuring the coordination and
424 continuity of care for covered persons (i) referred to specialty
425 physicians, or (ii) using ancillary services, including, but not limited to,
426 social services and other community resources and for ensuring
427 appropriate discharge planning for covered persons using such
428 ancillary services;

429 (I) The health carrier's process for enabling covered persons to
430 change their designation of a primary care provider, if applicable;

431 (J) The health carrier's proposed plan for providing continuity of
432 care to covered persons in the event of contract termination between
433 the health carrier and any of its participating providers or in the event
434 of the health carrier's insolvency or other inability to continue
435 operations. Such description shall explain how covered persons will be
436 notified of such contract termination, insolvency or other cessation of
437 operations and transitioned to other participating providers in a timely
438 manner;

439 (K) The health carrier's process for monitoring access to specialist
440 services in emergency room care, anesthesiology, radiology, hospitalist
441 care and pathology and laboratory services at such health carrier's
442 participating hospitals;

443 (L) The health carrier's efforts to ensure that its participating
444 providers meet available and appropriate quality of care standards
445 and health outcomes for network plans that such health carrier has
446 designed to include health care providers and facilities that provide
447 high quality of care and health outcomes;

448 (M) The health carrier's accreditation by the National Committee for
449 Quality Assurance that such health carrier meets said committee's

450 network adequacy requirements or by URAC that such health carrier
451 meets URAC's provider network access and availability standards; and

452 (N) Any other information required by the commissioner to
453 determine the health carrier's compliance with this section.

454 (3) A health carrier shall post each access plan on its Internet web
455 site and make such access plan available at the health carrier's business
456 premises in this state and to any person upon request, except that such
457 health carrier may exclude from such posting or publicly available
458 access plan any information such health carrier deems to be
459 proprietary information that, if disclosed, would cause the health
460 carrier's competitors to obtain valuable business information. A health
461 carrier may request the commissioner not to disclose such information
462 under section 1-210.

463 (i) (1) If the commissioner determines that (A) a health carrier has
464 not contracted with a sufficient number of participating providers to
465 assure that its covered persons have accessible health care services in a
466 geographic area, (B) a health carrier's access plan does not assure
467 reasonable access to covered benefits, (C) a health carrier has entered
468 into a contract that does not conform to the requirements of this
469 section or section 2 of this act, or (D) a health carrier has not complied
470 with a provision of this section or section 2 or 3 of this act, the health
471 carrier shall modify its access plan or implement a corrective action
472 plan, as appropriate, and as directed by the commissioner. The
473 commissioner may take any other action authorized under this title to
474 bring a health carrier into compliance with this section and sections 2
475 and 3 of this act.

476 (2) The commissioner may adopt regulations, in accordance with the
477 provisions of chapter 54, to implement the provisions of this section
478 and sections 2 and 3 of this act.

479 Sec. 2. (NEW) (*Effective January 1, 2017*) (a) As used in this section:
480 (1) "Covered person", "facility" and "health carrier" have the same

meanings as provided in section 38a-591a of the general statutes, (2) "health care provider" has the same meaning as provided in subsection (a) of section 38a-477aa of the general statutes, and (3) "intermediary", "network", "network plan" and "participating provider" have the same meanings as provided in subsection (a) of section 38a-472f of the general statutes, as amended by this act.

(b) (1) Each contract entered into, renewed or amended on or after January 1, 2017, between a health carrier and a participating provider shall include:

(A) A hold harmless provision that specifies protections for covered persons. Such provision shall include the following statement or a substantially similar statement: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.";

(B) A provision that in the event of a health carrier or intermediary

514 insolvency or other cessation of operations, the participating provider's
515 obligation to deliver covered health care services to covered persons
516 without requesting payment from a covered person other than a
517 coinsurance, copayment, deductible or other out-of-pocket expense for
518 such services will continue until the earlier of (i) the termination of the
519 covered person's coverage under the network plan, including any
520 extension of coverage provided under the contract terms or applicable
521 state or federal law for covered persons who are in an active course of
522 treatment, as set forth in subdivision (2) of subsection (g) of section
523 38a-472f of the general statutes, as amended by this act, or are totally
524 disabled, or (ii) the date the contract between the health carrier and the
525 participating provider would have terminated if the health carrier or
526 intermediary had remained in operation, including any extension of
527 coverage required under applicable state or federal law for covered
528 persons who are in an active course of treatment or are totally
529 disabled;

530 (C) (i) A provision that requires the participating provider to make
531 health records available to appropriate state and federal authorities
532 involved in assessing the quality of care provided to, or investigating
533 grievances or complaints of, covered persons, and (ii) a statement that
534 such participating provider shall comply with applicable state and
535 federal laws related to the confidentiality of medical and health
536 records and a covered person's right to view, obtain copies of or
537 amend such covered person's medical and health records; and

538 (D) Definitions of what is considered timely notice and a material
539 change for the purposes of subdivision (2) of subsection (c) of this
540 section.

541 (2) The contract terms set forth in subparagraphs (A) and (B) of
542 subdivision (1) of this subsection shall (A) be construed in favor of the
543 covered person, (B) survive the termination of the contract regardless
544 of the reason for the termination, including the insolvency of the health
545 carrier, and (C) supersede any oral or written agreement between a
546 health care provider and a covered person or a covered person's

547 authorized representative that is contrary to or inconsistent with the
548 requirements set forth in subdivision (1) of this subsection.

549 (3) No contract subject to this subsection shall include any provision
550 that conflicts with the provisions contained in the network plan or
551 required under this section, section 38a-472f of the general statutes, as
552 amended by this act, or section 3 of this act.

553 (4) No health carrier or participating provider that is a party to a
554 contract under this subsection shall assign or delegate any right or
555 responsibility required under such contract without the prior written
556 consent of the other party.

557 (c) (1) At the time a contract subject to subsection (b) of this section
558 is signed, the health carrier or such health carrier's intermediary shall
559 disclose to a participating provider all provisions and other documents
560 incorporated by reference in such contract.

561 (2) While such contract is in force, the health carrier shall timely
562 notify a participating provider of any change to such provisions or
563 other documents specified under subdivision (1) of this subsection that
564 will result in a material change to such contract.

565 (d) (1) (A) Each contract between a health carrier and an
566 intermediary entered into, renewed or amended on or after January 1,
567 2017, shall satisfy the requirements of this subsection.

568 (B) Each intermediary and participating providers with whom such
569 intermediary contracts shall comply with the applicable requirements
570 of this subsection.

571 (2) No health carrier shall assign or delegate to an intermediary such
572 health carrier's responsibilities to monitor the offering of covered
573 benefits to covered persons. To the extent a health carrier assigns or
574 delegates to an intermediary other responsibilities, such health carrier
575 shall retain full responsibility for such intermediary's compliance with
576 the requirements of this section.

577 (3) A health carrier shall have the right to approve or disapprove the
578 participation status of a health care provider or facility in such health
579 carrier's own or a contracted network that is subcontracted for the
580 purpose of providing covered benefits to the health carrier's covered
581 persons.

582 (4) A health carrier shall maintain at its principal place of business
583 in this state copies of all intermediary subcontracts or ensure that such
584 health carrier has access to all such subcontracts. Such health carrier
585 shall have the right, upon twenty days' prior written notice, to make
586 copies of any intermediary subcontracts to facilitate regulatory review.

587 (5) (A) Each intermediary shall, if applicable, (i) transmit to the
588 health carrier documentation of health care services utilization and
589 claims paid, and (ii) maintain at its principal place of business in this
590 state, for a period of time prescribed by the commissioner, the books,
591 records, financial information and documentation of health care
592 services received by covered persons, in a manner that facilitates
593 regulatory review, and shall allow the commissioner access to such
594 books, records, financial information and documentation as necessary
595 for the commissioner to determine compliance with this section and
596 section 38a-472f of the general statutes, as amended by this act.

597 (B) Each health carrier shall monitor the timeliness and
598 appropriateness of payments made by its intermediary to participating
599 providers and of health care services received by covered persons.

600 (6) In the event of the intermediary's insolvency, a health carrier
601 shall have the right to require the assignment to the health carrier of
602 the provisions of a participating provider's contract that address such
603 participating provider's obligation to provide covered benefits. If a
604 health carrier requires such assignment, such health carrier shall
605 remain obligated to pay the participating provider for providing
606 covered benefits under the same terms and conditions as the
607 intermediary prior to the insolvency.

608 (e) The commissioner shall not act to arbitrate, mediate or settle (1)
609 disputes regarding a health carrier's decision not to include a health
610 care provider or facility in such health carrier's network or network
611 plan, or (2) any other dispute between a health carrier, such health
612 carrier's intermediary or one or more participating providers, that
613 arises under or by reason of a participating provider contract or the
614 termination of such contract.

615 Sec. 3. (NEW) (*Effective January 1, 2017*) (a) As used in this section:
616 (1) "Covered person", "facility" and "health carrier" have the same
617 meanings as provided in section 38a-591a of the general statutes, (2)
618 "health care provider" has the same meaning as provided in subsection
619 (a) of section 38a-477aa of the general statutes, and (3) "intermediary",
620 "network", "network plan" and "participating provider" have the same
621 meanings as provided in subsection (a) of section 38a-472f of the
622 general statutes, as amended by this act.

623 (b) (1) Each health carrier shall post on its Internet web site a current
624 and accurate participating provider directory, updated at least
625 monthly, for each of its network plans. The health carrier shall ensure
626 that consumers are able to view all of the current participating
627 providers for a network plan through a clearly identifiable link or tab
628 on such health carrier's Internet web site, without being required to
629 create or access an account or enter a policy or contract number.

630 (2) Each health carrier shall provide, upon request from a covered
631 person or a covered person's representative, a print copy of such
632 directory or of requested information from such directory.

633 (c) (1) A health carrier shall include in each such electronic or print
634 directory the following information in plain language: (A) A
635 description of the criteria the health carrier used to build its network;
636 (B) if applicable, a description of the criteria the health carrier used to
637 tier its participating providers; (C) if applicable, a description of how
638 the health carrier designates the different participating provider tiers
639 or levels in the network and identifies, for each specific participating

640 provider, in which tier each is placed, such as by name, symbols or
641 grouping, to allow a consumer to be able to identify the participating
642 provider tiers; and (D) if applicable, a statement that authorization or
643 referral may be required to access some participating providers.

644 (2) Each such directory shall also include a customer service
645 electronic mail address and telephone number or an Internet web site
646 address that covered persons or consumers may use to notify the
647 health carrier of any inaccurate participating provider information in
648 such directory.

649 (3) Each health carrier shall make it clear for each such electronic or
650 print directory which directory applies to which network plan, such as
651 by including the specific name of the network plan as marketed and
652 issued in this state.

653 (4) Each such electronic or print directory shall accommodate the
654 communication needs of individuals with disabilities and include an
655 Internet web site address or information regarding available assistance
656 for individuals with limited English proficiency.

657 (d) (1) The health carrier shall make available through an electronic
658 participating provider directory, for each of its network plans, the
659 following information in a searchable format:

660 (A) For health care providers, (i) the health care provider's name,
661 gender, participating office location or locations, specialty, if
662 applicable, medical group affiliations, if any, facility affiliations, if
663 applicable, participating facility affiliations, if applicable, (ii) any
664 languages other than English spoken by such health care provider, and
665 (iii) whether such health care provider is accepting new patients;

666 (B) For hospitals, the hospital name, the hospital type, such as acute,
667 rehabilitation, children's or cancer, the participating hospital location
668 and the hospital's accreditation status; and

669 (C) For facilities other than hospitals, by type, the facility name, the

670 facility type, the types of health care services performed at the facility
671 and the participating facility location or locations.

672 (2) In addition to the information required under subdivision (1) of
673 this subsection, the health carrier shall make available through the
674 electronic directory specified under subdivision (1) of this subsection,
675 for each of its network plans, the following information:

676 (A) For health care providers, the health care provider's contact
677 information, board certification and any languages other than English
678 spoken by clinical staff, if applicable;

679 (B) For hospitals, the hospital's telephone number; and

680 (C) For facilities other than hospitals, the facility's telephone
681 number.

682 (3) (A) Each health carrier shall make available in print, upon
683 request, the following participating provider directory information for
684 the applicable network plan:

685 (i) For health care providers, (I) the health care provider's name,
686 contact information, specialty, if applicable and participating office
687 location or locations, (II) any languages other than English spoken by
688 such health care provider, and (III) whether such health care provider
689 is accepting new patients;

690 (ii) For hospitals, the hospital name, the hospital type, such as acute,
691 rehabilitation, children's or cancer and the participating hospital
692 location and telephone number; and

693 (iii) For facilities other than hospitals, by type, the facility name, the
694 facility type, the types of health care services performed at such facility
695 and the participating facility location or locations and telephone
696 number or numbers.

697 (B) Each health carrier shall include with the print directory

698 information under subparagraph (A) of this subdivision and in the
699 print participating provider directory under subdivision (2) of
700 subsection (a) of this section a statement that the information provided
701 or included is accurate as of the date of printing, that covered persons
702 or prospective covered persons should consult the health carrier's
703 electronic participating provider directory on such health carrier's
704 Internet web site and that covered persons may call the telephone
705 number on such covered person's insurance card for more information.

706 (4) For the information required to be included in a participating
707 provider directory pursuant to subdivisions (1) and (2) of this
708 subsection, each health carrier shall make available through such
709 directory the sources of such information and any limitations on such
710 information, if applicable.

711 (e) Each health carrier shall periodically audit at least a reasonable
712 sample size of its participating provider directories for accuracy and
713 retain documentation of such audit to be made available to the
714 commissioner upon request.

715 Sec. 4. Section 19a-904a of the 2016 supplement to the general
716 statutes is repealed and the following is substituted in lieu thereof
717 (*Effective January 1, 2017*):

718 (a) On and after January 1, 2016, each health care provider shall,
719 prior to any scheduled admission, procedure or service, for
720 nonemergency care, determine whether the patient is covered under a
721 health insurance policy. If the patient is determined not to have health
722 insurance coverage or the patient's health care provider is out-of-
723 network, such health care provider shall notify the patient, in writing,
724 electronically or by mail, (1) of the charges for the admission,
725 procedure or service, (2) that such patient may be charged, and is
726 responsible for payment for unforeseen services that may arise out of
727 the proposed admission, procedure or service, and (3) if the health care
728 provider is out-of-network under the patient's health insurance policy,
729 that the admission, service or procedure will likely be deemed out-of-

730 network and that any out-of-network applicable rates under such
731 policy may apply. Nothing in this subsection shall prevent a health
732 care provider from charging a patient for such unforeseen services.

733 (b) Each health care provider and health carrier shall ensure that
734 any notice, billing statement or explanation of benefits submitted to a
735 patient or insured is written in language that is understandable to an
736 average reader.

737 (c) No health care provider shall collect or attempt to collect from an
738 insured patient any money owed to such health care provider by such
739 patient's health carrier.

740 Sec. 5. Subsection (a) of section 38a-477e of the 2016 supplement to
741 the general statutes is repealed and the following is substituted in lieu
742 thereof (*Effective January 1, 2017*):

743 (a) On and after July 1, 2016, each health carrier, as defined in
744 section 38a-1084a, shall maintain an Internet web site and toll-free
745 telephone number that enables consumers to request and obtain: (1)
746 Information on in-network costs for inpatient admissions, health care
747 procedures and services, including (A) the allowed amount for, at a
748 minimum, admissions and procedures reported to the exchange
749 pursuant to section 38a-1084a for each health care provider in the state;
750 (B) the estimated out-of-pocket costs that a consumer would be
751 responsible for paying for any such admission or procedure that is
752 medically necessary, including any facility fee, coinsurance,
753 copayment, deductible or other out-of-pocket expense; and (C) data or
754 other information concerning (i) quality measures for the health care
755 provider, (ii) patient satisfaction, to the extent such information is
756 available, (iii) [a list of in-network health care providers], (iv) whether a
757 health care provider is accepting new patients, and (v) languages
758 spoken by health care providers] a directory of participating providers,
759 as defined in section 38a-472f, as amended by this act, in accordance
760 with the provisions of section 38a-472f, as amended by this act; and (2)
761 information on out-of-network costs for inpatient admissions, health

762 care procedures and services.

763 Sec. 6. Section 38a-478d of the general statutes is repealed and the
764 following is substituted in lieu thereof (*Effective January 1, 2017*):

765 For any contract delivered, issued for delivery, renewed, amended
766 or continued in this state, each managed care organization shall:

767 (1) [Provide at least annually to each enrollee a listing of all
768 providers available under the provisions of the enrollee's enrollment
769 agreement, in writing or through the Internet at the option of the
770 enrollee;

771 (2) Include] Provide at least annually to each enrollee a provider
772 directory that conforms to the requirements of section 3 of this act.
773 Such directory shall include, under a separate category or heading,
774 participating advanced practice registered nurses; [in the listing of
775 providers specified under subdivision (1) of this section;] and

776 [(3)] (2) For a managed care plan that requires the selection of a
777 primary care provider:

778 (A) Allow an enrollee to designate a participating, in-network
779 physician or a participating, in-network advanced practice registered
780 nurse as such enrollee's primary care provider; and

781 (B) Provide notification [, as soon as possible] in accordance with
782 subsection (g) of section 38a-472f, as amended by this act, to each such
783 enrollee upon the termination or withdrawal of the enrollee's primary
784 care provider.

785 Sec. 7. Section 38a-478h of the general statutes is repealed and the
786 following is substituted in lieu thereof (*Effective January 1, 2017*):

787 (a) Each contract delivered, issued for delivery, renewed, amended
788 or continued in this state between a managed care organization and a
789 participating provider shall [require the provider to give at least sixty

790 days' advance written notice to the managed care organization and
 791 shall require the managed care organization to give at least sixty days'
 792 advance written notice to the provider in order to withdraw from or
 793 terminate the agreement] conform to the requirements of section 2 of
 794 this act and shall include notice provisions for the removal or
 795 departure of such provider in accordance with subsection (g) of section
 796 38a-472f, as amended by this act.

797 [(b) The provisions of this section shall not apply: (1) When lack of
 798 such notice is necessary for the health or safety of the enrollees; (2)
 799 when a provider has entered into a contract with a managed care
 800 organization that is found to be based on fraud or material
 801 misrepresentation; or (3) when a provider engages in any fraudulent
 802 activity related to the terms of his contract with the managed care
 803 organization.]

804 [(c)] (b) No managed care organization shall take or threaten to take
 805 any action against any provider in retaliation for such provider's
 806 assistance to an enrollee under the provisions of section 38a-591g.

This act shall take effect as follows and shall amend the following sections:		
Section 1	January 1, 2017	38a-472f
Sec. 2	January 1, 2017	New section
Sec. 3	January 1, 2017	New section
Sec. 4	January 1, 2017	19a-904a
Sec. 5	January 1, 2017	38a-477e(a)
Sec. 6	January 1, 2017	38a-478d
Sec. 7	January 1, 2017	38a-478h

Statement of Legislative Commissioners:

In Section 1(a)(1)(A) and (B), "a person" was changed to "an individual" for accuracy; Section 1(a)(1)(C) was rearranged for clarity; Section 1(c)(1)(B) was redrafted for consistency with standard drafting conventions; in Section 1(c)(2), the designators were changed for consistency with standard drafting conventions; in Section 1(i)(1), "title

38a" was changed to "this title" for accuracy; and in Section 2(b)(2), "subdivision (2)" was changed to "subdivision (1)" for accuracy.

INS *Joint Favorable Subst. -LCO*